Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Consent to Screen, Evaluate And/Or Treatment of Services

Patient Name: _____ Date of Birth: _____

Address: _____

Patient's Primary Care Doctor: _____

Primary Care Doctor Phone Number: _____

- ❑ Speech Therapy
- ❑ Occupational Therapy
- ❑ ABA Therapy

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number:_____

Secondary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number:_____

I authorize Cornerstone Behavioral Health and Pediatric Therapies to screen, evaluate, and provide any subsequent treatment needed based on the evaluation results for the above named child.

Guardian Signature: _____ Date:_____

Guardian Printed Name: _____ Date: _____

Relationship to Patient : ☐ Parent ☐ Legal Guardian ☐ Other: _____

Signature of Cornerstone Representative:_____ Date:_____

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Case History Form

Child's Name: _____ Birthdate: ____/____/_____ Sex: □ M □ F

Father's Name: _____ Daytime Phone: _____

Home Address: _____ City:_____Zip:_____

Cell Phone: _____

E-mail: _____

Mother's Name: _____ Daytime Phone: _____

Home Address: _____ City:_____Zip:_____

Cell Phone: _____

E-mail: _____

Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one)**:**

□ Birth Parents □ Adoptive Parents □ Foster Parents

□ Parent and Step-Parent □ One Parent □ Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing or Learning Problems

___

Child's race/ethnic group:

□ Caucasian, Non-Hispanic □ Hispanic □ Native American

□ Asian or Pacific Islander □ African-American □ Other_____

Is there a language other than English spoken in the home? □ Yes □ No

If yes, which one?_____ Does the child speak the language? □ Yes □ No

Does the child understand the language? □ Yes □ No

Who speaks the language?_____

Which language does the child prefer to speak at home? _____

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Speech-Language-Hearing History

Do you feel your child has a speech problem? □ Yes □ No

If yes, please describe.

_____

_____

__

Do you feel your child has a hearing problem? □ Yes □ No

If yes, please describe:_____

_____

Has he/she ever had a speech evaluation/screening? □ Yes □ No

If yes, where and when? _____

What were the results? _____

Has he/she ever had a hearing evaluation/screening? □ Yes □ No

If yes, where and when? _____

What were the result?_____

Has your child ever had speech therapy? □ Yes □ No

If yes, where and when? _____

What was he/she working on? _____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? □ Yes □ No

If yes, please describe:_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

What do you see as your child's most difficult problem in the home?

_____

_

What do you see as your child's most difficult problem in school?_____

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Medical Background:

Pregnancy and Birth History:

Were there any complications during pregnancy with your child? ☐ YES ☐ NO

Please circle all that apply: Alcohol use Cigarette use Substance use

Hypertension Preeclampsia Diabetes

Preterm labor Preterm delivery Other: _____

Were there any complications of the birth/delivery of this child? ☐ YES ☐ NO

Please circle all that apply: Jaundice Hypoglycemia Fetal distress Failure to thrive

Feeding difficulties Genetic condition: _____

Other: _____

Gestational age at time of delivery:_____

What type of delivery (please circle)? Vaginal Cesarean Section- elective or emergency

Birth Weight: _____

Length: _____

Was your child in the NICU? ☐ YES ☐ NO

If so, how long? _____

Please describe any complications that occurred during NICU hospitalization:

_____

_____

_____

Were there any additional complications during your child's first year of life? ☐ YES ☐ NO

If so, please describe: _____

_____

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Health History:

It is very important to have as complete of a medical history for your child as possible. Please fill out the grid below making sure to include an explanation for any question answered "yes". In your explanation please include your child's age at which the event occurred, any diagnoses made and any treatments which occurred.

YES	NO	DESCRIPTION	EXPLANATION
		Frequent colds/respiratory illness	
		Frequent strep throat/sore throat	
		Frequent ear infections (tubes?)	
		Birth defects/genetic disorder	
		Lung condition/respiratory disorder	
		Allergies or asthma	
		Heart condition	
		Anemia/blood disorder	
		Kidney/renal disorder	
		Urinary problems/infections	
		Hormonal problems	
		Muscle disorder/problems	
		Joint/bone problems (x-rays, bone scans)	
		Fractured bones	
		Skin disorder/skin problems (eczema)	
		Visual disorder/vision problems	
		Eye infections	

		Neurological disorder	
		Seizures or convulsions (include any EEG's)	
		Stomach disorder/pain	
		Vomiting/digestion problems	
		Failure to gain weight/feeding problems	
		Constipation/diarrhea problems	
		Dehydration episodes	
		Hearing loss/ear disorder	
		Significant accidents	
		Head injuries/concussions	
		Ingestion of toxins, poisons, foreign objects	
		MRI/CAT scan	
		Chronic medications (for what? when?)	
		Major childhood illness (pox, coup, measles, mumps, meningitis, etc.)	

Hospitalizations/Surgeries including approximate dates: _____

_____

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Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone

_____ babbled

_____put two words together

_____walked

_____grasped crayon/pencil

_____ said first words

_____spoke in short sentences

_____ toilet trained

Does your child...

□ choke on food or liquids?

□ currently put toys/objects in his/her mouth?

□ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

□ repeat sounds, words or phrases over and over?

□ understand what you are saying?

□ retrieve/point to common objects upon request (ball, cup, shoe)?

□ follow simple directions ("Shut the door" or "Get your shoes")?

□ respond correctly to yes/no questions?

□ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

□ body language.

□ sounds (vowels, grunting).

□ words (shoe, doggy, up).

□ 2 to 4 word sentences.

□ sentences longer than four word □ other _____

Behavioral Characteristics:

□ cooperative	□ attentive	□ willing to try new activities
□ separation difficulties of time	□ restless	□ plays alone for reasonable length
□ destructive/aggressive	□ stubborn	□ easily frustrated/impulsive
□ self-abusive behavior	□ poor eye contact	□ easily distracted/short attention
□ withdrawn	□ inappropriate behavior	□ easily frustrated/impulsive

School History

If your child is in school, please answer the following:

Name of school and grade in school:

Teacher's name:

Has your child repeated a grade?

What are your child's strengths and/or best subjects?

Is your child having difficulty with any subjects?

Is your child receiving help in any subjects?

Additional Comments

_____

_____

_____

Cornerstone
BEHAVIORAL HEALTH
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Cornerstone Behavioral Health and Pediatric Therapies, Inc.

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies, Inc. at (405) 455-6868 or by email at office@cornerstoneok.org

This Notice of Privacy Practices describes how Cornerstone Behavioral Health and Pediatric Therapies may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Cornerstone Behavioral Health and Pediatric Therapies is required to abide by the terms of this Notice of Privacy Practices. Cornerstone Behavioral Health and Pediatric Therapies may change the terms of this notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION: Treatment: Information about you may be used by the personnel (including students in the field of speech- language pathology who are completing extern placements) associated with Cornerstone Behavioral Health and Pediatric Therapies for diagnosis, treatment planning, and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information only to clients or the parents/guardians of clients if clients are minors. In some cases, should Cornerstone Behavioral Health and Pediatric Therapies need to send information to another professional, a signed Release of Information form is required.

Payment: Cornerstone Behavioral Health and Pediatric Therapies bills directly to insurance companies. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered that are not covered by your insurance in addition to any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in ways you have provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Cornerstone Behavioral Health and Pediatric Therapies.

OTHER DISCLOSURES: Cornerstone Behavioral Health and Pediatric Therapies may use or disclose your protected health information in some situations without your authorization or providing you the opportunity to agree or object. Some of these situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification

and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been

approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Copies can be obtained for $.25 a page.

Under federal law, however, you may not inspect or copy records related to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

COMPLAINTS: If you believe your rights have been violated by Cornerstone Behavioral Health and Pediatric Therapies please bring the problem to our attention first. Your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the Clinical Director, Dr. Gotcher, PhD (ngotcher@cornerstoneok.org or 405-455-6868) handles a complaint, you may submit a formal complaint to:

Attn: Director Office for Civil Rights U.S. Department of Health and Human Services 200 Independence

Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

This notice was published and becomes effective on signed date below. It will remain in effect for two years from this date.

_____ _____

Legal Guardian Signature Date

_____ _____

Cornerstone Representative Signature Date

Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Authorization for Release of Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize Cornerstone to release information TO:

1. Name of Provider/ Facility:_____

Address:_____

Phone number:_____

Fax number:_____

Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

2. Name of Provider/ Facility:_____

Address:_____

Phone number:_____

Fax number:_____

Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider/Facility:_____

Address:_____

Phone number:_____

Fax number:_____

Information requested/authorized: ☐ Evaluation ☐ Records ☐ Other: _____

_____ _____

Signature of Parent or Guardian Date

_____ _____

Cornerstone Representative Date

Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Financial Responsibility Statement

Patient full name: _____

Patient's DOB: ____/____/_____

Primary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of birth: _____

Member ID Number: _____ Group Number: _____

Phone Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Cornerstone Behavioral Pediatrics, and authorize Cornerstone Behavioral Pediatrics to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

By signing this form I am stating that I understand and agree to the following:
Fees for services were reviewed with me and agreed upon prior to the commencement of services. Payment is due at the time services are rendered unless other arrangements have been made. All returned checks will result in a $25.00 return fee. Failure to meet financial obligations will result in termination of services.

I, _____, (print name) assume all financial responsibility for charges related to all services provided by Cornerstone BH&PT for _____ (print child's name).

_____ _____

Signature of Parent or Legal Guardian Date

Cornerstone
BEHAVIORAL HEALTH
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Patient Attendance Policy

Consistent therapy attendance is critical for your child's success. Cornerstone requires consistent attendance as your child's therapy appointment time is specifically reserved just for them. We realize that children do get sudden illnesses and that emergencies occur. Our attendance policy allows for some flexibility to accommodate those situations.

Early notification of a cancellation is vital as it allows us to provide services to other children waiting to be seen for therapy. It also allows us a better opportunity to re-schedule your child to another time during the week to make up for the missed visit. It is expected that canceled visits be rescheduled in order to comply with your child's plan of care and physician's order. Please contact our office at 405-455-6868 if your child is unable to attend his regularly scheduled therapy appointment. All requests for changes in your child's therapy schedule will need to be discussed with your child's therapist and front office staff.

In order to allow us to meet the needs of our current patients and those on the waitlist to be seen, we have attendance policies that must be followed. A violation of these policies will result in your child being taken off the therapy schedule and potentially discharged from services.

Appointment Cancellation Policy:

- Please call or email the office at least 2 weeks in advance, to notify for pre-planned absences, ie., vacations, other appointments, etc.
- Call the office at least 24 hours in advance to cancel or reschedule appointments for unplanned absences.
- Cancellations under 24 hours are acceptable only due to illness, death in the family, or other significant family emergencies.
- Any missed visit without 24 hour notice will result in a $50.00 charge.

  We try to offer appointment times that are most convenient for your busy schedule. If you need to reschedule your appointment with short notice, please understand that you may need to see another therapist, accept a less than optimal appointment time, or wait until the next scheduled opening becomes available.

In the following instances, your child will be taken off the therapy schedule and potentially discharged from services:

- **Cancellation of 3 appointments per discipline with less than 24 hours notice in a 90 day period for any reason.**
- **Cancellation of 2 appointments per discipline for any reason that are not rescheduled (regardless of advance notice) in a 90 day period.**
- **No showing for 2 appointments in a 90 day period. No showing is defined as not providing notice of non attendance prior to the scheduled appointment time.**
- **Arriving late, or late to pick up your child, for therapy 3 times in a 90 day period.**

Drop Off Policy: Cornerstone acknowledges that your time is valuable. With therapist approval, parents/guardians may leave the premises during their child's treatment sessions if we have an emergency contact number to reach you. If you do not have an emergency contact number, we require that you remain on the premises. If your emergency contact number changes, it is your responsibility to update the information with us. Cornerstone therapists value parental involvement and the implementation of therapeutic strategies in the home setting. For this reason we kindly request that you be available 5-10 minutes PRIOR to the end of your child's therapy so that the staff may talk with you and educate you on therapeutic strategies and progress. If you are unavailable 10 minutes prior to the end of the treatment session or arrive late to pick up your child, the therapist may not be able to address strategies or questions as they have other children waiting to be seen for therapy.

**Medicaid clients will not be charged the fee*

ILLNESS

For the safety of other children and our staff, please do not bring your child to therapy if your child is ill. When your child is sick, please call the clinic to cancel your appointment as soon as possible. Below are guidelines to assist you in deciding whether your child should attend the appointment.

If a child arrives and/or is brought to Cornerstone Behavioral Health & Pediatric Therapies and is believed to be ill or contagious, the guardian will be contacted immediately and will be responsible for picking up, or making arrangements for picking up, the child as soon as possible.

Children should be kept at home when they meet the following criteria:

- Temperature of 99.9°, or higher, in the past 24 hours.
- Conjunctivitis ("pink eye"), pink/redness of the eye and/or lids, usually with yellow discharge and crusting.
- Bronchitis, COVID-19*, virus/flu with hoarseness, cough, and fever.
- A rash you cannot identify which has not been diagnosed.
- Impetigo: red pimples, which become small vesicles surrounded by a reddened area. When blisters break, the surface is raw and weeping. Look for signs in neck creases, groin, underarms, face, hands, or edge of diaper.
- Diarrhea three or more times within 24 hours (watery or greenish BM's that look different and are more frequent than usual).
- Vomiting within 24 hours (more than usual "spitting up").
- A severe cold with fever, sneezing, and nose drainage.
- An unknown illness without obvious symptoms other than unusual paleness, irritability, tiredness, or lack of interest.
- A contagious disease, including measles, chicken pox, mumps, roseola, strep throat, etc.
- Hair lice (same as public school policy).

While we regret the inconvenience caused by strict adherence to these guidelines, our concern for all the children dictates a very conservative approach when dealing with health matters.

Safe Return After an Illness:

Usually a child can return to the clinic under these circumstances:

- The child has been fever free without fever reducing medication for 24 hours.
- The child has been diagnosed as having a bacterial infection and has been on an antibiotic for 24 hours.
- It has been 24 hours since the last episode of vomiting or diarrhea.
- The nasal discharge is not thick, yellow, or green.
- Eyes are no longer discharging, or the condition has been treated with an antibiotic for 24 hours.
- Ringworm- antibiotic treatment and keep the area covered

  Other rash has subsided, or a physician has determined that the rash is not contagious.

*__Physician documentation is required.__

Inclement Weather

- In the event of inclement weather, Cornerstone Administration will closely monitor the weather and notify patients about clinic closures via text or telephone.
- During prolonged weather events, daily updates will be sent via text and/or email regarding closure, delayed openings or early closings.
- Occasionally, we may reopen the office if it is determined that streets are clear and safe for travel.
- If you are unable to keep an appointment due to weather conditions, please notify the clinic at Ext.1, as soon as possible.

**Please be informed that if your insurance requires a prior-authorization for therapy and you only attend a portion of your sessions, your insurance company will likely reduce the number of visits in future authorizations or completely deny future requests.*

Acknowledgment- I have read the attendance policy and acknowledge my understanding as well as agree to the terms.

_____

Patient Name

_____ _____

Signature of Parent or Guardian Date